Hospital Outpatient Services...

Do I really need to worry about compliance??

Objectives for Presentation Today

- Learn key compliance issues for outpatient services
- Discuss ways to improve compliance in small offices
- Identify outpatient services “hot buttons” for compliance

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COMPLIANCE

- NOT a four letter word
- But strikes fear, boredom, and contempt in even the best of us
- Historically, coders have taken the stance “I just code what’s given me….compliance is not my concern
- Compliance is especially ignored in small physician practices as likelihood of audit risk is low

So...Why Is This Stuff Important?

- Healthcare is a highly regulated industry...more than most
- Because the Federal Government is paying more and more healthcare costs, their regulations, efforts to monitor expenditures, and penalties for non-compliance grow and grow...
In many businesses you can and do reward top sources of referrals . . .

. . . in healthcare, this can land you in jail

Examples of Fraud, Waste, and Abuse

- Billing for Services Not Provided, or Billing for a Higher Paying Service (*Upcoding*)
- Misrepresenting Diagnosis to Justify Payment
- Unbundling Charges
- Falsifying Certificates of Medical Necessity or Treatment Plans
- Improper Referrals or Kickbacks
- Even under- or down-coding
The targets for compliance prosecution...

Some recent cases---
- February 2012—OIG says physicians that assign Medicare billing rights still liable for any false claims.
- January 2012—Nurse pleads guilty in $25 million health care fraud scheme
- December 2011—14 healthcare providers arrested in New Jersey for “cash-for-referrals” deal.
- December 2011—Department of Justice “recovers” a record $5.6 Billion in Fraud
- November 2011—OIG Audit reveals 43% inaccuracy in claims and recoups $175,000 in overpayments.
- May 2010—Pennsylvania doctor gets 1 year in jail and 3 years of monitored activities
- December 2009—Michigan Provider pays $669,413 to Settle False Claims Allegations
- June 2008—Cardiologist pays $1.4 million over Improper Patient Referrals
- April 2006—Office Manager Gets 7 Years
- September 2005 - Clerk Gets 2 Years in Prescription Drug Scam

Who enforces compliance?

U.S. GOVERNMENT:
- U.S. Dept. of Health & Human Services: Office of Inspector General (OIG)
- Office of Civil Rights
- United States Department of Justice (DOJ)
  - Federal Bureau of Investigation
  - United States Attorney’s Office
  - Drug Enforcement Administration

STATE AGENCIES (Examples)
- Medicaid Fraud Control Unit
- Office of the Attorney General

OTHER: DOZENS OF AGENCIES REGULATE HOSPITALS
OIG Work Plan--2012

- Compliance with Assignment Rules (such as accepting Medicare for payment in full)
- Physicians with unusually high payment levels
- High cumulative Part B payments
- OIG work “continues to identify overpayments...to physicians that incorrectly billed and coded place of service on the claim
- “Incident-to” services—HIGH interest
- Physicians that bill Medicare but “opted out”

...and MORE OIG Work Plan foci

- Coding trends in E&M claims from 2000-2009
- Documentation of E&M services using EHR
- Medical record review for E&M services
- EHR: Cloning, over documentation, pre-populated templates
- Incorrect use of modifiers (especially “57” and “24”) that could result in improper payments
- Sleep testing procedures
- RADIOLOGY
- Hemoglobin A1C tests
- Outpatient dental claims
- Ambulatory Surgical Centers—Safety and Quality
So what can an outpatient office do??

“What We’d LIKE to do…..”
What we CAN do—Establish a Compliance Program!!

A compliance program:
- Is a systematic, transparent approach to comply with all applicable laws and regulations
- Integrates strategic goals of organization
- Aims to detect and deter instances of fraud, waste, and abuse
- Responds to new government initiatives for participation

Who Should have a Compliance Program?
- Hospitals—OIG Guidance 1998, 2005
- Physician Groups—OIG Guidance 2000
- Private practices—OIG Guidance 2000
- LTC facilities—OIG Guidance 2000
- Clinical laboratories—OIG Guidance 1998

All entities receiving Medicare/Medicaid funds should consider establishing a compliance programs. New regulations and Affordable Care Act will require compliance programs for specific programs.
Reasons to Implement a Compliance Program

- Furthers mission of providing quality healthcare
- Facilitates legal duty to refrain from submitting false or erroneous claims or cost information
- Increases ability to detect and correct unlawful or unethical behavior at an early stage
- Encourages employees to raise questions, report potential problems, and help HHSC comply with all Federal laws.
- May potentially decrease criminal sanctions if/when there is a violation and there is a compliance program in place that was designed to detect and prevent violations of law and was routinely relied upon by individuals within the organization

Core Elements of Effective Compliance Program

- Code of Conduct and Policies and Procedures
- Chief Compliance and Privacy Officer (“CCPO”), Regional Compliance Officers (“RCOs”) and Compliance Committee
- Education and Training
- Internal Reporting
- Disciplinary Standards and Hiring Criteria
- Auditing and Monitoring
- Investigation, Response and Prevention
Key Legal Elements Used in Compliance

- Federal physician self-referral law (Stark)
- Federal anti-kickback statute
- False Claims Act
- FERA 2009
- Emergency Medical Treatment and Labor Act (EMTALA)
- HIPAA Privacy and Security Rules
- Medicare and Medicaid regulations
- HITECH (2009)
- Patient Protection and Affordability Care Act (2010)
- Health Care and Education Affordability Reconciliation Act (2010)

Stark Law in a Nutshell

Prohibits Physician from referring:

- Who: Any Medicare/Medicaid patients
- What: For the provision of “designated health services”
- Where: To a Facility in Which Physician or Physician's Immediate Family has a "Financial Relationship."
Strict Liability

The Stark law is a “strict liability law.” Under the Stark law, lack of deliberate intent or knowledge is not an excuse. **Proof of intent is not needed.** If a physician financial arrangement violates Stark, all referrals by that physician are void and possible fines and prosecution could happen.

Stark Law: Covered Services

Stark covers the following **Designated Health Services:**
- clinical laboratory services
- physical therapy services
- occupational therapy services
- radiology or other diagnostic services (including MRI, CT and ultrasound)
- radiation therapy services and supplies
- durable medical equipment
- parenteral and enteral nutrients, equipment and supplies
- prosthetics, orthotics and prosthetic devices and supplies
- home health services
- outpatient prescription drugs
- **inpatient and outpatient hospital services**
Stark: A Financial Relationship?

- “Financial Relationship” means:
  “any arrangement involving any remuneration between a physician and an entity ... directly or indirectly, overtly or covertly, in cash or in kind.”

- Includes direct and indirect ownership and compensation arrangements, including ownership through debt as well as equity, stock options and indirect ownership via different entities at any level.

How to Address Stark Law: Exceptions

- Stark Law allows referrals by physicians under a financial arrangement with another covered entity IF the financial arrangement clearly meet one of the 35 “exceptions” included in the law.

- Commonly used exceptions: Written Agreements, leases, employment, in-office ancillary services
Stark Law Penalties

Both hospital/clinic and physician subject to sanctions:

- If the arrangement (a) meets Stark Criteria and (b) does NOT fall within a specific exception then it is illegal *per se*

  Sanctions include denial of payment for the service, civil monetary penalties of $15,000 to $100,000 per violation and exclusion from the Medicare and/or Medicaid programs.

Anti-kickback Statute

The Anti-Kickback Statute (AKS) prohibits the knowing and deliberate receiving of some remuneration (not just money) in return for referring someone to a person or entity for healthcare that is paid for by any federally funded health care program.
Anti-kickback Law in a Nutshell

- Intent Based Statute

  - Unlike Stark, specific intent to violate AKS must be shown.

  - However, federal courts have interpreted this statute broadly, ruling that a violation need not include proof of an overt agreement to make referrals and that intent may be inferred from the circumstances. *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995).

Addressing the Anti-kickback Law: Safe Harbors

Like Stark, the AKS includes exceptions called “Safe Harbors.” If a physician financial arrangement involving remuneration falls under one of these safe harbors, then the referrals are allowed.

Commonly used Safe Harbors: Employment, personal services, and management exceptions

Arrangements must be fair market value, in writing, etc.
Anti-Kickback Penalties

Sanctions - Up to $25,000 and 5 years imprisonment for each violation

HIPAA

Health Insurance Portability and Accountability Act (HIPAA) passed in 1996 is the Federal law that governs the privacy rights of patients and the confidentiality of protected health information (PHI).
HIPAA: Keeping Protected Health Information Private

HIPAA and Protected Health Information (PHI)

PHI is information that identifies health information on a patient. PHI can be in any form including written, verbal, conversational, or electronic. PHI includes any information that could allow someone to identify the patient such as name, address, phone numbers, social security numbers, room number, medical record number, email addresses, medical notes, medical diagnoses. Maintaining confidentiality of PHI is even a bigger challenge in small communities.
HIPAA: Sharing PHI

Outpatient Staff are allowed to share protected health information (PHI) of patients under HIPAA for treatment, payment, or healthcare operations without patient approval if it is part of your job duties.

Changing World of Compliance for Coders and their Physicians

Compliance enforcement more important and complicated than ever with:
- Changes in existing laws
- New ways to “slice the Medicare pie”
- Increased Auditing enforcement tools
- National Healthcare Reform
False Claims Act

The False Claims Act (FCA) is the key law used to enforce compliance.

The FCA is a Civil War era statute that criminalizes “knowing” presentation to government of false or fraudulent claim for payment.

“KNOWINGLY....”

- Acting with knowledge of the claim’s truth or falsity
- Acting in deliberate ignorance of the claim’s truth or falsity
- Acting in reckless disregard of the claim’s truth or falsity
Knowingly Submitting a Claim….

Medicare claim form 1500 submitted by or for the physician for payment states…. “I certify that the services shown on this form were medically necessary for the health of the patients and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.”

Changes in Compliance: False Claims Act

The False Claim Act was modified in 2009 by the Fraud Enforcement and Recovery Act (FERA) law. It’s now clearly illegal “fraud” when a hospital or physician knowingly keeps overpayments or money paid to them due to a billing error or wrong payment.
FERA—Redefined “FRAUD”

- Credit Balances…..

False Claims: 60 Days to Refund

- Once identified…..

1 2 3
Changes in Compliance: Auditing Efforts

Centers for Medicare and Medicaid (CMS) now has authority for systematic audits/reviews of claims through:

- CERT—Comprehensive Error Rate Testing
- RAC—Recovery Audit Contractors
- MIC—Medicaid Integrity Contractors
- ZPIC—Zone Program Integrity Contractors
- MAC—Medicare Administrative Contractors

Audits and Reviews—What are they looking for?

- CMS estimates that incorrect claims cost the government billions of dollars.
- Medical necessity issues have represented a significant portion of the Medicare fee-for-service payment error rate calculated by the government.
- For every $1 invested in enforcement, Government recoups $10.
Audits and Reviews: Ensuring Services meet CMS Criteria

- Only when medically necessary
- Provided with quality which meets professionally recognized standards of health care
- Provided economically
- Supported by evidence in the medical record

FY 07 Overpayments Collected by Type of Error
Inpatient and Outpatient Hospital Claims

- Incorrect Coding: 42%
- Medical Unnecessary: 32%
- No / Insufficient Documentation: 9%
- Other: 17%
- $131 m
- $120 m
- $30 m
- $50 m
Why RACs Will Continue….

Payments Identified by Type of Improper Payment

- 3% Overpayment
- 97% Underpayment

CERT Program

- Audits aimed at measuring improper payments
- “…to calculate a national paid claims error rate for all of the Medicare Fee-For-Service program. The CERT program calculates the error rates for all Medicare Administrative Contractors (MACs) and, until the transition to MACs is completed, the CERT program will also report on Carriers, and Fiscal Intermediaries (FIs).” [CMS Homepage]
**ZPIC Audits**

- “Zone Program Integrity Contractors”
- Target potential fraud in Medicare and audit the integrity of *all* Medicare claims for a particular provider with both pre- and post-pay audits
- VERY Broad

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**Action Areas To Prepare for RAC**

- Physician documentation improvement
- Coder education and training
- DRG validation and benchmarking
- HIM operational assessment
  - To ensure effective and compliant medical records request processes
- Charge Assignment validation
  - Charge Description Master
  - Charge Protocols
RAC Automated Claim Reviews

Examples

- Non-covered services
- Coding errors
- Duplicate payments
- Medically unlikely edits
- Technical denials from complex medical reviews
- Incorrect units of service
- Indicative of incorrect charge assignment protocols
- Charge description master designation
- Can bill for only 1 unit per encounter
- Blood product transfusions
- Drugs/pharmaceuticals
- Speech therapy
  - Multiple units billed
  - Missing modifiers that would impact payments
  - Payment for discontinued HCPC/CPT codes

How MICs Work

- Conduct post-payment audits of Medicaid providers
- Combination of desk audits and field audits
- Fee-for-service audits now; later to add cost report and managed care audits.
- Will identify overpayments, but will not be involved in collection.
- Fewer parameters than the RAC
Audits and Reviews: Consequences

- Recoupment of funds owed due to incorrect claim and/or undocumented medical necessity
- Fines and imprisonment depending on intent and extent of the issues
- Exclusion from Medicare/Medicaid

Audit and Reviews: Big Bucks!

- FY 2005—$1.5 Billion Recovered by DOJ
- FY 2006—RAC process identified almost $300 million in overpayments
- FY 2006—RAC efforts netted the government a 373% return of investment
- FY 2007—RAC process identified $357.2 million in improper payments
- FY 2009—DOJ opens 886 new fraud cases
- FY 2009—HHS investigations recovered $2.5 billion
Audits and Reviews: Documentation

- Documentation, including coding, by physicians is critical.
- HIM/Coding experts and Utilization Review and can help the physician document and code the claim correctly.

Changes in Compliance: HITECH Act

Health Information Technology for Economic and Clinical Health Act (HITECH):

- Provides funds, with many regulations, for EHR implementation
- Changes HIPAA to require notification for data breaches involving protected health information
- Business Associates now covered by HIPAA and must notify when breaches occur
HITECH: HIPAA Breaches

- January 2012—250 breaches reported affecting 7.8 million people!
- Covered entities required to notify patients and depending on number of records breached different reporting requirements.
- Much stricter notification requirements.

Changes in Compliance: Healthcare Reform

Patient Protection and Affordability Care Act (2010) and Health Care and Education Affordability Reconciliation Act (2010) include:
- 60 day deadline for paying back overpayments
- Changes making it easier for “whistle blowers” to report compliance issues
- Stark changes excluding physician owned hospitals and in-office ancillary services exception for imaging services
- Giving OIG more tools for enforcement
- Expanding RAC program
- Changes in how services are bundled for payment
- Requirement for provider enrollment in Medicare/Medicaid if ordering Medicare covered items
- NPI must be included on all Medicare payment claims
- Requirements for increased documentation for DME, home health services, and other services TBA by the HHS secretary
What Can Coders do Now?

- Ask Questions
- Raise issues to physicians and billers—don’t hibernate 😊
- Be vigilant about modifiers and “incident-to” and provide education to providers
- Ensure that there are no duplicative claims
- Double-check point of service
- Pay attention to 99214, 99223, and 99233
- Perform analysis of E&M data for peer groups.
- Use MGMA’s “Coding Profile Book”
- Use CMS’s Medicare Utilization data

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So (again) WHY is Compliance Important to Professional Coders?

- It’s the law
- Affects payments for your services
- Affects participation in Federal healthcare programs
- Has severe fines and consequences for non-compliance
- Coding if the foundation for much of the healthcare reform!

Endnotes....

- Used in Presentation:
  - AR Systems Presentation by Virginia Gleason, JD/MPA, LPN, CHC, CPHRM; Regulatory Compliance Consultant
  - King & Spalding: Proposed HITECH (And More) Changes to HIPAA Privacy, Security and Enforcement Rules, August 11, 2010
  - HCCA “OIG Work Plan” webinars—11/7 and 11/8 2011
  - MedeAnalytics Webinar—Fall, 2011

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